

WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 6: 3 - 9 February 2018
Data as reported by 17:00; 9 February 2018



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New events

54

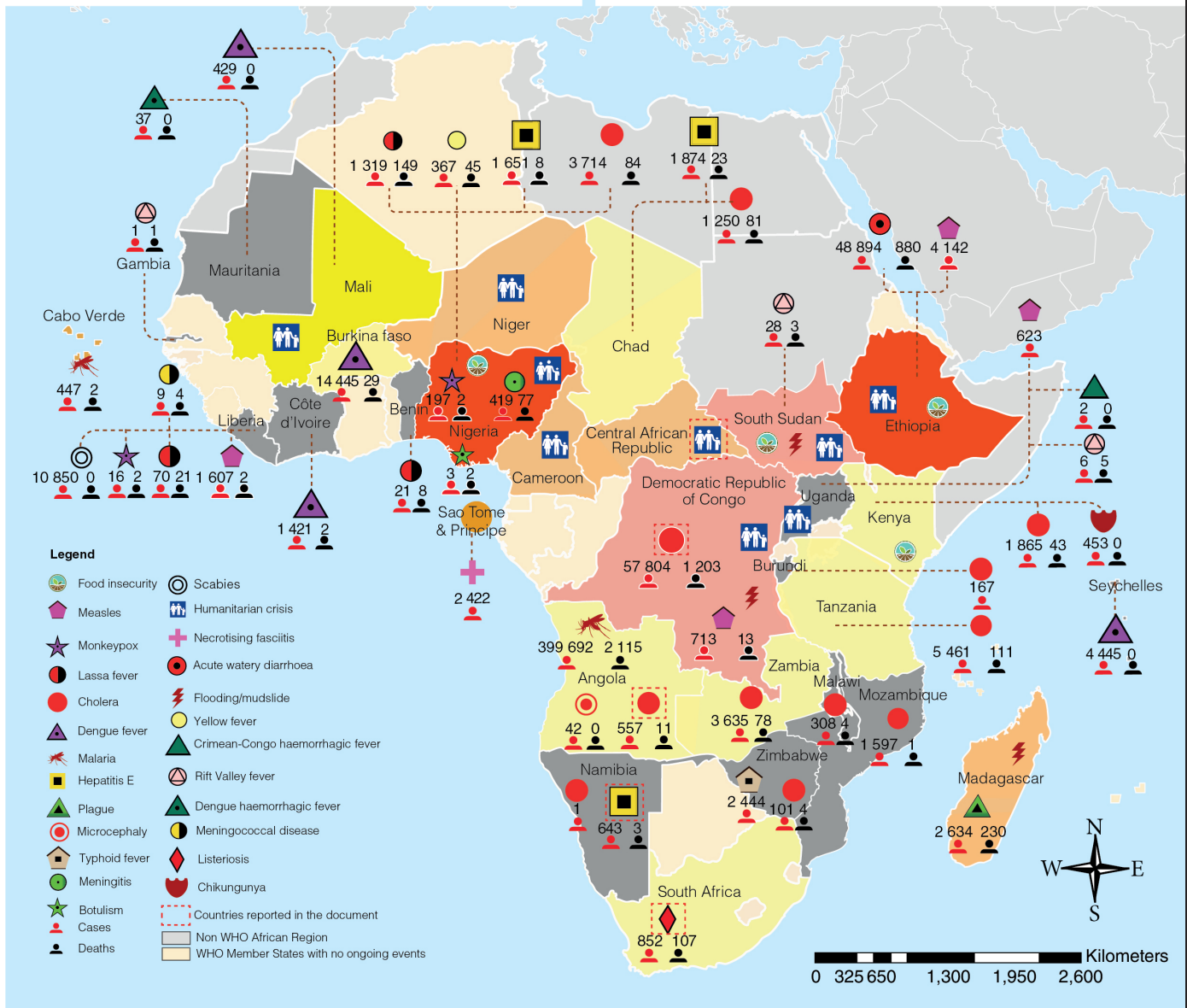
Ongoing events

43

Outbreaks

11

Humanitarian crises



2

Grade 3 events

6

Grade 2 events

8

Grade 1 events

34

Ungraded events

2

Protracted 3 events

1

Protracted 2 events

1

Protracted 1 event

Overview

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- This Weekly Bulletin focuses on selected acute public health emergencies occurring in the WHO African Region. The WHO Health Emergencies Programme is currently monitoring 54 events in the region. This week's edition covers key new and ongoing events, including:
 - Declaration of the end of cholera outbreak in South Sudan
 - Humanitarian crisis in Central African Republic
 - Cholera in Democratic Republic of the Congo
 - Hepatitis E in Namibia
 - Cholera in Angola
 - Listeriosis in South Africa
- For each of these events, a brief description followed by public health measures implemented and an interpretation of the situation is provided.
- A table is provided at the end of the bulletin with information on all new and ongoing public health events currently being monitored in the region, as well as events that have recently been closed. Since the beginning of the year, ten events have been controlled and closed including outbreaks of foodborne illness in Benin, influenza A H1N1 in Ghana, malaria in Kenya, Crimean-Congo haemorrhagic fever in Mauritania, meningitis and hepatitis E in Niger, dengue fever in Senegal, cholera in South Sudan, cholera in Uganda, and anthrax in Zambia.
- **Major challenges include:**
 - The humanitarian crisis in Central African Republic has deteriorated in recent weeks, with increased episodes of violence since late December 2017. Although WHO and other partners are engaged in the response, the security situation has resulted in the temporary withdrawal of some actors who were previously providing services to affected populations. National and international actors need to scale up actions to stabilize the situation urgently to allow needed humanitarian aid to continue to be provided.
 - The listeriosis outbreak in South Africa is of concern because of its national scale and lack of identification of the source of the outbreak. Case investigation activities and testing of food and environmental samples need to be accelerated to facilitate the identification of the source of contamination and implementation of response measures to bring the outbreak to an end.

Declaration of the end of cholera outbreak in South Sudan

20 438
Cases

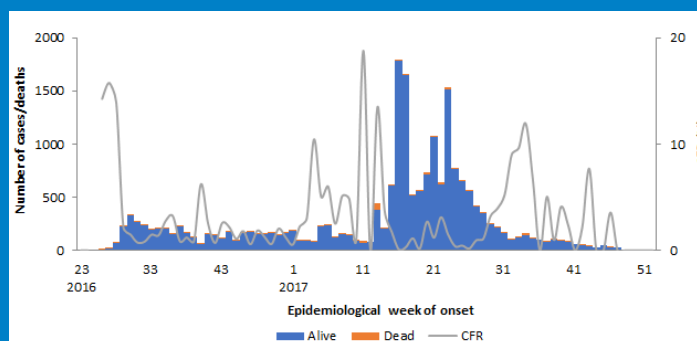
436
Deaths

2.1%
CFR

EVENT DESCRIPTION

On 7 February 2018, South Sudan declared the end of its longest and largest cholera outbreak in the context of a complex humanitarian crisis, with no new cases reported in over seven weeks. The outbreak was declared on 18 June 2016 and affected many parts of the country, including 27 counties and the capital Juba. As of the declaration of the end of the outbreak, a total of 20 438 cases including 512 confirmed cases and 436 deaths (case fatality rate 2.1%) have been reported. The most affected counties were Ayod, Tonj East, Yirol East, Fashoda, Kapoeta East and Kapoeta South. The most affected populations in these areas were those living around landing sites and towns on the River Nile, cattle camp dwellers, populations living on islands with no services, and internally displaced people (IDPs) with inadequate access to water, sanitation, and hygiene (WASH) facilities. Case fatality rates were highest in counties with poor access to healthcare, particularly populations on islands and in cattle camps. The last confirmed case was discharged from hospital on 18 December 2017.

Distribution of cholera cases and deaths in South Sudan, Week 23 of 2016 to Week 52 of 2017



PUBLIC HEALTH ACTIONS

- ▶ The response to the cholera outbreak was coordinated by a national taskforce led by the Ministry of Health with the participation of WHO, UNICEF, and Health and WASH cluster partners.
- ▶ The government of South Sudan worked with the European Union Humanitarian Aid (ECHO), GAVI, the Vaccine Alliance, WHO, and USAID to secure 2.2 million doses of oral cholera vaccine (OCV) from the GAVI-funded global stockpile.
- ▶ More than 885 000 people in cholera-affected and high risk populations received the first round of the vaccine and nearly 500 000 people also received a second round of the vaccine. Due to security challenges, the recommended two doses could not be administered to the entire population targeted, which would have significantly decreased their risk of cholera infection.
- ▶ On 7 February 2018, WHO issued a press release to note the major achievement that had been made towards cholera control in South Sudan.

SITUATION INTERPRETATION

Cholera cases have been confirmed in South Sudan every year since 2013. However, the 2016-2017 cholera outbreak was the longest and largest in magnitude and geographical extent, resulting largely from the humanitarian crisis, the associated population displacement, insecurity, and declining investment in WASH. Since the onset of the humanitarian crisis, access to safe water and sanitation facilities has declined to approximately 60% and less than 10%, respectively. In the light of these challenges, the containment of the recent outbreak represents a major achievement, and demonstrates the effectiveness of extensive oral cholera vaccination campaigns and concerted efforts by the national authorities and humanitarian actors to stop the outbreak.

With the start of the rainy season in a few months, the risk of cholera is expected to increase, and national authorities must remain vigilant and ready to act swiftly to respond to new cases. Because the country is dealing with several complex health emergencies with 5.1 million people in need of health assistance, there is already a huge burden on the country's health system, which could hamper response to a future outbreak. National and international partners should work to strengthen the sanitation infrastructure in the country as part of a long-term national strategy for cholera control.

Ongoing events

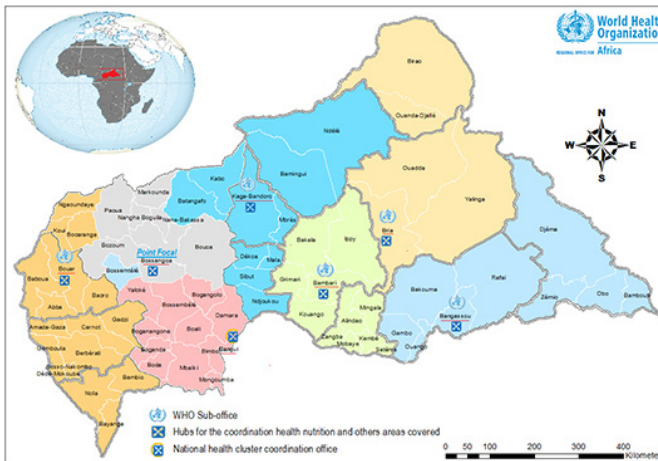
Humanitarian crisis

Central African Republic

EVENT DESCRIPTION

The security situation across Central African Republic remains a concern, with renewed violence in the northeast, eastern, and central areas of the country since the second half of December 2017. Violent attacks, including looting and destruction of health centres, have forced the temporary withdrawal of some NGOs and health staff, and resulted in continued population displacement. The number of internally displaced people (IDPs) has increased by more than 70%, from 402 240 in January 2017 to 688 700 in early 2018. The specific hot spots in recent weeks include Batangafo, Bria, Kembé, Ippy, and Paoua sub-prefectures. In the sub-prefecture of Batangafo, the Ouogo health facilities were looted and the Kambakota health facility was burnt. The Batangafo sub-prefecture hosts 36 355 IDPs, most (91.6%) of whom are living in IDP sites. According to OCHA, the city of Bria was host to 73 075 IDPs as of late December 2017. The Ippy sub-prefecture currently hosts 7 706 IDPs, who live on the Catholic church site and are under permanent threat from the armed group controlling the city. In Kembé sub-prefecture, several houses were burnt during attacks on 4 January 2018, causing seven civilian deaths, with others wounded. The health centre was looted, including drug stocks, and the NGO Community Humanitarian Emergency Board International (COHEB) temporarily withdrew from the site. The city of Paoua (population 20 000) has received more than 65 000 IDPs since 28 December 2017. Support to health structures by humanitarian partners has been suspended in Paoua sub-prefecture due to insecurity, leaving seven out of the 23 health units in the sub-prefecture non-functional.

WHO and Health cluster presence in Central African Republic as of February 2018



Malnutrition remains a problem and the humanitarian community has been alerted to a significant increase in malnutrition among the population of Mobaye and its surrounding areas.

Since the beginning of 2018, two deaths from rabies were recorded by Médecins sans Frontières (MSF) in Batangafo and Kabo; one human case of rabies was reported from Ouandago. In Bangui there have been 62 bites by dogs suspected as being positive for rabies from weeks 1 to 3 of 2018. However, rabies was not confirmed in samples sent to the Institut Pasteur, Bangui.

PUBLIC HEALTH ACTIONS

- ▶ WHO and partners continue to support the Ministry of Health in restoring health services in areas affected by the ongoing violence. A WHE consultant has been deployed to Paoua to strengthen the coordination of nutrition and health interventions in the area. WHO, the United Nations Population Fund (UNFPA), the International Committee of the Red Cross (ICRC) and the Catholic Organization for Relief and Development Aid (CORDAID) have provided support to partners in the health sector in Paoua for continuation of free healthcare for 100 000 people (IDPs and host communities) over the next 3 months.
- ▶ Humanitarian actors are preparing a multi-sectoral assessment of affected areas in Batangafo.
- ▶ OCHA has convened an inter-cluster meeting (Nutrition, Health and Safety) in Mobaye to plan an assessment of the malnutrition situation in the area.
- ▶ WHO prepositioned rabies vaccines and immunoglobulin at the Ouandago Health Centre and provided 200 doses of rabies vaccine and 40 doses of immunoglobulin to MSF in Batangafo and Kabo. The Ministry of Livestock is planning a dog vaccination campaign during 2018, with support from the Food and Agriculture Organization of the United Nations (FAO).
- ▶ The Ministry of Health, with the support of WHO, UNICEF and other partners have planned a mass measles and polio vaccination campaign in Paoua from 8-11 February 2018, targeting 46 000 children from 6 months to 14 years and 17 300 children less than five years of age. This will be coupled with screening for malnutrition among children aged 6 to 59 months.
- ▶ WHO will provide financial support to the Ministry of Health for the operational costs of distributing long-lasting insecticide-treated bed nets to the population of Paoua in early February 2018.

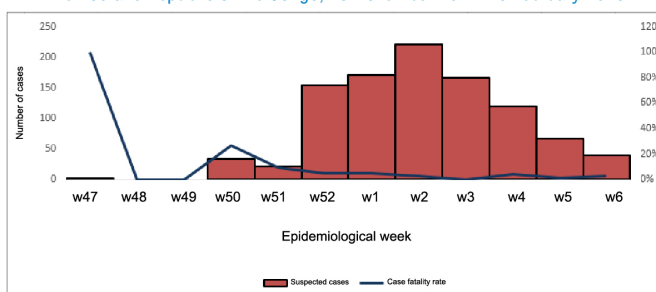
SITUATION INTERPRETATION

The security situation in Central African Republic continues to hamper the provision of humanitarian aid, and although all partners are engaged, the humanitarian crisis will continue if actions are not scaled up to increase security in the country. There is a very real danger that this situation will escalate during 2018 and national and international actors need to attempt to stabilize the situation urgently, in order to allow humanitarian aid to continue to be provided to vulnerable populations.

EVENT DESCRIPTION

The trend of the cholera outbreak continues to significantly decrease in Kinshasa, the capital city, and nationwide. The outbreak in Kinshasa started on 25 November 2017 and was exacerbated by heavy rainfall and flooding during the first week of 2018. As of 9 February 2018, 997 cases including 41 deaths (case fatality rate 4.1%) have been reported from 31 of 35 health zones in Kinshasa province. The majority (77.4%) of the cases were reported from Binza-Météo (429 cases), Kintambo (174 cases) and Limete (162 cases) health zones. The case fatality rate in those three health zones is greater than 3%; the last death recorded occurred in the community on 7 February 2018. The weekly incidence of cholera in Kinshasa has been decreasing since week 3 of 2018. Since the beginning of the outbreak, 135 stool samples were analyzed, of which 74 tested positive for *Vibrio cholerae*.

Epidemic curve of suspected cholera cases and case fatality rate in Kinshasa, Democratic Republic of the Congo, 25 November 2017 – 9 February 2018



Nationwide, a total of 645 suspected cases with four deaths (case fatality rate 0.6%) were reported in week 4 (ending 28 January 2018, the most recent data available), as compared to 679 suspected cases with 16 deaths (case fatality rate: 2.4%) in the previous week. Sixty-five percent of the cases reported during week 4 were concentrated in three provinces: North Kivu, South Kivu and Kinshasa. A total of 57 804 cases with 1 203 deaths (case fatality rate 2.1%) have been reported between week 1 of 2017 and week 4 of 2018. In 2017, a total of 54 588 cases and 1 145 deaths were reported nationally; this is almost double the number of cases reported in 2016.

PUBLIC HEALTH ACTIONS

- ▶ WHO continues to support the Ministry of Health in its surveillance and response activities in affected provinces.
- ▶ WHO has deployed 20 international experts to the Democratic Republic of Congo and repurposed over 50 staff members based in the country to assist with outbreak response. Staff are primarily deployed to Kinshasa, but have also been deployed to the Kasai and North Kivu regions.
- ▶ In Kinshasa, MSF Belgium continues to support case management in the three cholera treatment units (CTUs): Pakadjuma, Luka and Bumbu. As of 9 February 2018, there were six inpatients receiving care at the CTUs: Pakadjuma (5) and Luka (1).
- ▶ WHO has provided funds to support WASH and risk communication activities in the community.
- ▶ The National Cholera Elimination Program is preparing to implement interventions to improve WASH conditions in universities and prisons.

SITUATION INTERPRETATION

Cholera is endemic in the Democratic Republic of the Congo (DRC). Sporadic cases and outbreaks are common, particularly in the eastern provinces of the country. Kinshasa is not one of the provinces in which cholera is endemic, but has reported several cholera outbreaks over the last few years. Although the weekly case incidence has been decreasing, more rainfall is anticipated in March, which could result in an upsurge of cases if key risk factors are not urgently addressed. Community sensitization activities, enhancement of surveillance, and case management activities currently supported by national authorities, WHO, and other partners, should continue to be prioritized in Kinshasa in order to stop cholera transmission and reduce the risk of regional spread.

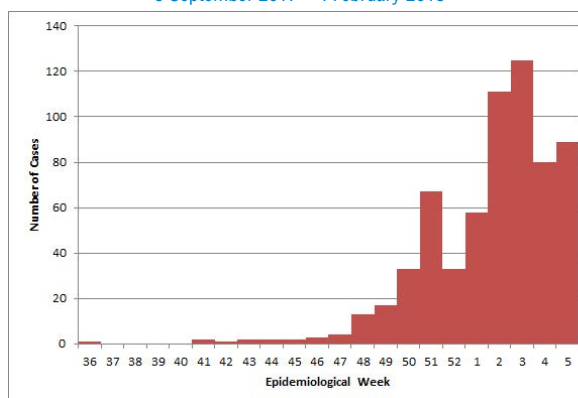
*These are the national totals from week 1 of 2017 to week 4 of 2018. More recent national data are not yet available.

EVENT DESCRIPTION

The hepatitis E outbreak in Namibia continues to evolve. Between 8 September 2017 and 4 February 2018, a cumulative total of 643 cases patients were reported, including 50 cases confirmed by serology (IgM). Three cases died (case fatality rate 0.5%), all of whom were women who died post-delivery. The reported weekly number of cases peaked in the third week of January 2018, with 125 cases reported, then declined to 89 cases for the week ending 4 February 2018. Most cases (76%) are between 20 and 39 years of age and the majority (57%) of the cases are male.

Most cases have been reported from informal settlements within the capital, Windhoek, with 332 (52%) cases reported from Havana and 168 (26%) from Goreagab informal settlements. An estimated 89% of the population of these two areas use communal water points and 62% practice open defecation. Confirmed cases have been reported from elsewhere in the country, namely Omusati (four cases), Oshana (two cases), and Oshikoto (one case) regions. However, all were imported from Havana informal settlement and have been contained in those regions.

Epidemic curve of suspected hepatitis E cases in Namibia, 8 September 2017 – 4 February 2018

**PUBLIC HEALTH ACTIONS**

- Multi-sectoral regional and national health emergency management committees were activated and are coordinating response activities. The national committee is made up of five thematic working groups including 1) surveillance, epidemiology, and laboratory, 2) case management and infection prevention and control, 3) coordination and logistics, 4) social mobilization and communication, and 5) water, sanitation, and hygiene (WASH) and environmental health.
- The Ministry of Health has fully funded a national outbreak response plan and procurement of materials for outbreak response is ongoing.
- The President of Namibia and the Minister of Health visited Havana informal settlement on 2 February 2018 to demonstrate the government's commitment to controlling the outbreak.
- Namibian Field Epidemiology and Laboratory Training Program (FELTP) epidemiologists, Ministry of Health community health workers, and Red Cross volunteers, are conducting active case finding in the community and health facilities, referral to health facilities for treatment, and distribution of water purification tablets and education on hepatitis E prevention to households. Identification of cases among pregnant women and education of pregnant women living in informal settlements about hepatitis E is being prioritized.
- The Ministry of Health is leading case management teams, with support from WHO, and all cases are being referred to a public hospital in Windhoek for specialized treatment. A maternity hospital has been identified as the referral facility for pregnant women identified as suspected cases.
- Case management protocols and algorithms have been disseminated to the health facilities to enhance case management.
- UNICEF has donated 25 000 bars of soap and 35 000 packets of water chlorination tablets (50 tablets per pack) to support implementation of WASH response activities.
- Education regarding hepatitis E symptoms, transmission, and prevention is being provided to pregnant women at antenatal care visits. Traditional birth attendants have also been made aware of the signs and symptoms of hepatitis E and have been requested to refer pregnant mothers to the nearest health facility.
- Efforts by the City of Windhoek, the Red Cross, UNICEF, and other partners are ongoing to provide clean water, hygiene-related supplies, and improve sanitation in the affected communities.
- The preparation of social mobilization activities is underway, with participation of the Ministry of Health, WHO, UNICEF, and the United Nations Population Fund (UNFPA).

SITUATION INTERPRETATION

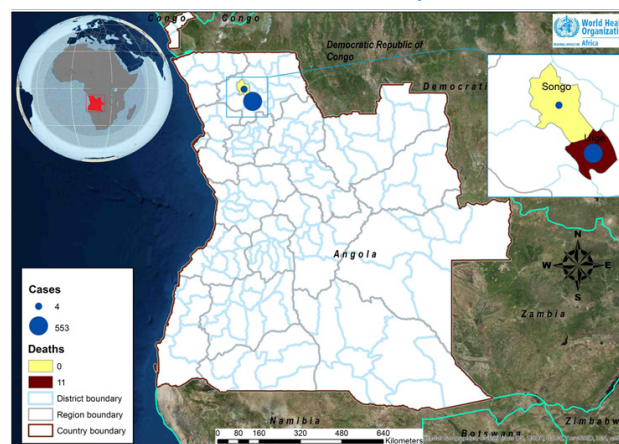
Active transmission of hepatitis E continues due to limited access to safe water and adequate sanitation facilities. These underlying risk factors should be urgently addressed through the implementation of WASH and environmental health interventions in order to prevent future cases. Inadequate human resources and capacity to ensure timely collection of surveillance data are important challenges and additional assistance from partners may be needed to ensure rapid case detection and response. Social mobilization activities and enhanced environmental testing to determine the source of the outbreak are also urgently needed to control this outbreak.

EVENT DESCRIPTION

Since our last report on the cholera outbreak in Uíge province, Angola (*see Weekly Bulletin 3*), the daily number of cases continues to decline, with approximately eight cases reported daily as of 3 February 2018, compared to a peak of 30 cases daily on 6 January 2018. In the week ending 3 February 2018, 35 cases, including one death were reported, and a total of 557 cases and 11 deaths (case fatality rate 2.0%) have been reported as of this date. The geographic distribution of cases has expanded to Songo district, where four cases and no deaths have been reported over the past 3 weeks. The vast majority (99.3%; 554) of cases and all deaths (11) have, however, been reported from Uíge district. Seven of these deaths occurred in the community and four occurred in healthcare facilities.

This outbreak of cholera was detected on 21 December 2017, when two suspected cases with a history of travel to Kimpangu in the Democratic Republic of the Congo presented to a healthcare facility in Uíge District, Uíge Province. Most cases are from the suburbs of the city of Uíge, which has limited access to safe water and improved sanitation. Only 16% of the cases reported using a piped water supply as their main source of drinking water; 21% of cases reported using river water, and 63% reported using wells. The majority (61%) of cases practiced open defecation. The National Public Health Laboratory confirmed the presence of *Vibrio cholerae* by culture in samples from a total of four cases, including the two initial cases. Two cases reported from Songo district were positive by *Vibrio cholerae* by rapid diagnostic testing.

Geographical distribution of cholera cases in Angola,
21 December 2017 – 3 February 2018

**PUBLIC HEALTH ACTIONS**

- ▶ The Ministry of Health continues to lead a multisectoral national response committee, which deployed a multidisciplinary rapid response team to Uíge and is coordinating the response with local authorities, WHO, UNICEF, Médecins Sans Frontières (MSF), and other partners.
- ▶ Enhanced surveillance, case management, and implementation of water, sanitation, and hygiene (WASH) interventions is ongoing in Uíge province, and risk communication messages regarding the importance of consuming safe drinking water have been disseminated to affected communities.
- ▶ Community surveillance staff have been trained and are supporting scale up of surveillance in Uíge and Songo districts. A team is closely monitoring Songo district, a new district where cases were recently reported.
- ▶ A cholera treatment centre was established by the Ministry of Health on 26 December 2017, and additional medicines and disinfection materials were deployed to the area from 29 December 2017 after local stocks were exhausted.
- ▶ WASH activities have been implemented at the hospital and community levels, and have included social mobilization, dissemination of information, education, and communication (IEC) materials, and the distribution of Aquatabs and treated water in affected areas.

SITUATION INTERPRETATION

In Angola, cholera is endemic, and there is an increase in the number of cases observed during the rainy season from September to April. Key factors contributing to the community deaths and overall high case fatality rate are the lack of access to health facilities in the neighbourhoods most affected by the outbreak and weak community-based cholera surveillance at the start of the outbreak. Rapid scale up of enhanced surveillance, case management, and WASH activities by the Ministry of Health, WHO, and partners have contributed to the continued decline in the number of reported cases. Long-term plans for cholera control will need to be developed and implemented in order to avoid spread to other parts of the country and to bring this outbreak to a halt.

EVENT DESCRIPTION

The outbreak of listeriosis in South Africa continues, with a decreasing trend in the number of cases since Week 50 of 2017. As of 5 February 2018, 852 laboratory confirmed cases have been reported since 1 January 2017, with a total of 107 deaths (case fatality rate 12.6%). Most cases have been reported from Gauteng Province (59%, 505/852), followed by Western Cape (13%, 107/852) and KwaZulu-Natal (7%, 63/852). Cases have been diagnosed in the public (66%, 558/852) and private (34%, 294/852) healthcare sectors. Diagnosis was most frequently based on isolation of *Listeria monocytogenes* in blood culture (71%, 609/852), followed by cerebrospinal fluid (CSF) (22%, 191/852). Where age was reported (n=823), ages ranged from birth to 93 years (median 19 years) and 42% are neonates aged 28 days or younger. Of neonatal cases, 96% had early-onset disease (birth to less than 7 days). Females accounted for 55% of cases for whom gender was reported. Final outcome data are available for 42% of cases, of which 30% (107/355) have died. The elderly and neonates are at increased risk for listeriosis; additional risk factors include pregnancy, immunocompromise and cancer. An investigation team continues to work on what is considered a strong lead between human cases and a food item; laboratory results are pending.

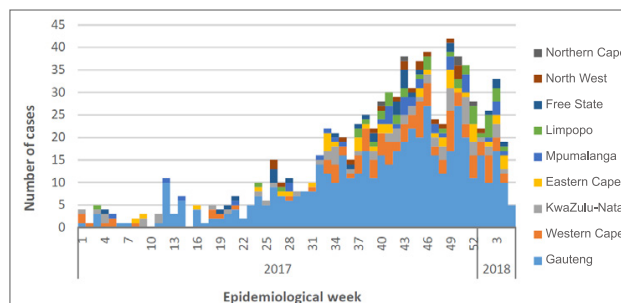
PUBLIC HEALTH ACTIONS

- ▶ WHO has deployed a food safety expert, an epidemiologist with expertise in listeriosis outbreak investigation, and a risk communication expert.
- ▶ Support and guidance was provided to environmental health practitioners on sampling and collection of specimens from food processing plants for laboratory testing.
- ▶ Technical support has been provided for surveillance and collection of case investigation data in order to identify the link between cases.
- ▶ A risk communication group has been supported to develop a communication strategy and appropriate listeriosis messaging.
- ▶ A case investigation is ongoing and is focusing on linking cases and any food or environmental samples that test positive for *Listeria monocytogenes*.

SITUATION INTERPRETATION

The lack of knowledge of the source of this large outbreak of listeriosis is of concern. Challenges include a long period before laboratory results are available, inadequate funding for laboratory testing given the large number of samples, infrequent and insufficiently detailed updates regarding the outbreak, and lack of finalization of risk communication materials. There is also insufficient capacity for data analysis to identify links between cases. All of these challenges need to be addressed as soon as possible in order to find the source of this outbreak and bring it to a close.

Epidemic curve of listeriosis cases in South Africa,
1 January 2017 to 5 February 2018



Summary of major challenges and proposed actions

Challenges

- The major population displacements resulting from recent violent attacks in Central African Republic represent a serious and worsening humanitarian crisis. The primary challenge remains the urgent need to increase security in the country so that humanitarian actors can resume provision of services to affected populations and scale up their activities to meet their needs.
- The listeriosis outbreak in South Africa continues to be investigated by national authorities, but the source of the outbreak has not yet been identified. Delays in testing of food and environmental samples related to inadequate funding for testing remains a key challenge to timely implementation of response activities.

Proposed actions

- National and international actors urgently need to improve the security situation in Central African Republic in order facilitate provision of needed assistance to internally displaced populations and other populations with humanitarian and health needs. If greater security in the country can be assured, humanitarian actors are urged to continue and to scale up assistance activities, with prioritization of those populations most severely affected by the crisis.
- Identification of additional funding for laboratory testing and increased collaboration with laboratories in-country will be needed to increase the pace of testing of food and environmental samples in South Africa. Linkage of the results of these samples with case investigation data is urgently needed to enable identification of the source of contamination and rapid implementation of measures to control the outbreak.

All events currently being monitored by WHO AFRO

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Ongoing events										
Angola	Cholera	G1	2-Jan-18	21-Dec-17	3-Feb-17	557	5	11	2.0%	Detailed update given above.
Angola	Malaria	Ungraded	20-Nov-17	1-Jan-17	30-Sep-17	399 692	-	2 115	0.5%	The outbreak has been ongoing since the beginning of 2017. In the province of Benguela, a total of 244 381 malaria cases were reported from January to September 2017 as compared to 311 661 reported in all of 2016. In the province of Huambo, 155 311 malaria cases were reported from January to September 2017, as compared to 82 138 cases during the same period in 2016. Epidemiological investigations are ongoing in these two contiguous provinces.
Angola	Microcephaly - suspected Zika virus disease	Ungraded	10-Oct-17	End September	29-Nov-17	42	-	-	-	A cluster of microcephaly cases was detected in Luanda in late September 2017 and reported on 10 October 2017 by the provincial surveillance system. Of the 42 cases, three were stillbirths and 39 were live births. Suspected cases have been reported from Luanda province (39), Zaire province (1), Moxico province (1), and Benguela province (1).
Benin	Lassa fever	Ungraded	13-Jan-18	8-Jan-18	8-Feb-18	21	5	8	38.1%	Twenty-one cases (5 confirmed, 2 probable and 14 suspected) including 8 deaths were reported from four departments: Atacora(8), Borgou(7), Collines(4) and Alibori (2). Eight cases were residents of Nigeria who subsequently traveled to Benin.
Burkina Faso	Dengue fever	G1	4-Oct-17	1-Jan-17	10-Dec-17	14 445	-	29	0.2%	Weekly case counts have decreased since week 44. The majority (62%) of cases have been reported in the central region, notably in Ouagadougou (the capital). Dengue virus serotypes 1, 2, and 3 are circulating, with serotype 2 predominating (72%).
Burundi	Cholera	Ungraded	20-Aug-17	15-Aug-17	6-Dec-17	167	14	0	0.0%	As of 6 December 2017, a cumulative total of 167 cases and no deaths were reported from 6 districts; DS Nyanza lac 30 cases, DS Mpanda 31 cases, DS Cibitoke 35 cases, DS Isare 33 cases, DS Bubanza 31 cases, and DS B M Nord 6 cases.
Cameroon	Humanitarian crisis	G2	31-Dec-13	27-Jun-17	3-Nov-17	-	-	-	-	In the beginning of November, the general security situation in the Far North Region worsened. Terrorist attacks and suicide bombings are continuing and causing displacement. Almost 10% of the population of Cameroon, particularly in the Far North, North, Adamaoua, and East Regions, is in need of humanitarian assistance as a result of the insecurity. To date, more than 58 838 refugees from Nigeria are present in Minawao Camp, and more than 21 000 other refugees have been identified out of the camp. In addition, approximately 238 000 Internally Displaced People have been registered.

Cape Verde	Malaria	G2	26-Jul-17	1-Jan-17	20-Dec-17	447	-	2	0.4%	As of 20 December, a total of 447 cases have been reported including 418 indigenous, 12 imported cases, and 17 reinfections/recurrences. Two deaths have been reported (1 in an indigenous case and 1 in an imported case). The outbreak has been contained to the city of Praia. Cases reported from other areas/islands likely acquired the infection during travel to Praia or overseas, and there is currently no evidence of indigenous transmission outside of Praia.
Central African Republic	Humanitarian crisis	G2	11-Dec-13	11-Dec-13	5-Feb-18	-	-	-	-	Detailed update given above.
Chad	Hepatitis E	G1	20-Dec-16	1-Aug-16	3-Dec-17	1 874	98	23	1.2%	Outbreaks are ongoing in the Salamat Region predominantly affecting North and South Am Timan, Amsiné, Mouraye, Foulouga and Aboudeia. The number of cases has been decreasing since week 39. Of the 64 cases in pregnant women, five died (CFR: 7.8%) and 20 were hospitalized. Water chlorination activities were stopped at the end of September 2017 due to a lack of partners and financial means. Monitoring and case management are continuing.
Chad	Cholera	G1	19-Aug-17	14-Aug-17	10-Dec-17	1 250	9	81	6.5%	The case incidence has been decreasing since week 43. In week 49, no new cases were reported. A total of 817 cases and 29 deaths were reported in the Salamat region from 11 September 2017 to 10 December 2017. No new cases have been reported in the Sila Region since 22 October 2017.
Cote d'Ivoire	Dengue fever	Ungraded	3-May-17	22-Apr-17	16-Dec-17	1 421	322	2	0.1%	The outbreak has been on a downward trend since week 35, with no cases being reported in weeks 49 and 50. This is likely due to the decrease in rainfall. Abidjan remains the epicentre of this outbreak, accounting for 95% of the total reported cases. Of the 272 confirmed cases with available information on serotypes, 181 were dengue virus serotype 2 (DENV-2), 78 were DENV-3 and 13 were DENV-1. In addition, 50 samples were confirmed IgM positive by serology.
Democratic Republic of the Congo	Flood	Ungraded	20-Nov-17	20-Nov-17	9-Feb-18	-	-	-	-	From 4-7 January 2018, a flooding event occurred in Kinshasa. The flood resulted in 45 deaths, 5 100 flooded homes, 192 collapsed houses and 2 damaged cholera treatment centres (CTCs). A total of 786 cholera cases and 18 deaths (CFR: 2.3%) have been reported in Kinshasa since the beginning of 2018.
Democratic Republic of the Congo	Humanitarian crisis	G3	20-Dec-16	17-Apr-17	22-Jan-18	-	-	-	-	The humanitarian crisis remains serious. An estimated 13.1 million people are in need of emergency aid assistance, including around 4.3 million Internally Displaced Persons (IDPs), and 552 000 refugees. In addition, an estimated 7.7 million people are at risk of critical food insecurity. More than 74% of the country's total IDPs are from Kasai region, North, and South Kivu. The humanitarian and security situation in North and South Kivu regions continue to deteriorate with massive population displacements recorded in the South Kivu region.
Democratic Republic of the Congo	Cholera		16-Jan-15	1-Jan-17	28-Jan-18	57 804	841	1 203	2.1%	Detailed update given above.
Democratic Republic of the Congo	Measles		10-Jan-17	1-Jan-18	14-Jan-18	713	-	13	1.8%	Over 43 000 cases were reported in 2017. In weeks 1 and 2 of 2018, 713 cases and 13 deaths were reported, with a stable weekly number of cases since week 52 of 2017. The trend of the outbreak has decreased this week. Most of the suspected cases this week were reported from South Kivu province.

Ethiopia	Humanitarian crisis	Protracted 3	15-Nov-15	n/a	28-Jan-18	-	-	-	-	The complex humanitarian crisis in Ethiopia continues into 2018. As of 28 January 2018, there were about 6.3 million people in need of health assistance, over 1.7 million people internally displaced, and over 900 000 refugees. Currently, Oromia region has 669 107 internally displaced people (IDPs) settled in various temporary sites and living with host communities in six zones over 43 woredas (districts).
Ethiopia	Acute watery diarrhoea (AWD)		15-Nov-15	1-Jan-17	28-Jan-18	48 894	-	880	1.8%	The outbreak is showing a downward trend. During weeks 3 and 4 of 2018, there were 11 AWD cases reported, down from 77 cases for weeks 1 to 2. To date, cases have been reported from Dire Dawa and Mustahil and Gode City, Shebelle Zone, Somali.
Ethiopia	Measles		14-Jan-17	1-Jan-17	28-Jan-18	4 142	-	-	-	The outbreak of measles continues to improve. Between week 1 and 4 of 2018, a total of 131 cases have been reported. Currently, Somali, Oromia, Addis Ababa, Amhara, Afar and Tigray Regions are having active outbreaks.
Gambia	Rift Valley fever (RVF)	Ungraded	3-Jan-17	25-Dec-17	3-Jan-18	1	1	1	100.0%	A 52-year-old man presenting with severe malaria was medically evacuated from the Gambia and hospitalized in Fann, Dakar. A blood sample collected from the case was positive for Rift Valley fever virus on IgM testing done at Institut Pasteur Dakar. The sample was negative for RVF and other arboviruses on PCR testing. An investigation is ongoing.
Kenya	Chikungunya	Ungraded	mid-December 2017	mid-December 2017	25-Jan-18	453	32	0	0.0%	As of 25 January 2018, 453 suspected cases were reported across seven sub-counties: Changamwe, Jomvu, Kilifi, Kisauni, Likoni, Mvita, and Nyal. The majority of suspected cases are reported from Mvita (31%) and Likoni (23%) sub-counties. To date, 32 samples tested positive for chikungunya on PCR analyses conducted at the KEMRI laboratory.
Kenya	Cholera	G1	6-Mar-17	1-Jan-17	24-Jan-18	1 865	431	43	2.3%	The outbreak is still ongoing and 6 counties are actively reporting cases: Garissa, Mombasa, Siaya, Tharaka Nithi, Meru, Busia counties. The outbreak was recently controlled in Kirinyaga.
Liberia	Meningococcal disease	Ungraded	19-Jan-18	23-Dec-18	29-Jan-18	9	2	4	44.4%	A cluster of undiagnosed illness and deaths were reported from Lofa county, northeastern Liberia. Samples taken from two suspected cases were positive for Neisseria meningitidis serogroup W. All seven samples collected as of 29 January were negative for Ebola and Lassa fever viruses by PCR, negative for yellow fever by serology (IgM), and negative for typhoid by WDAL. Additional testing is ongoing.
Liberia	Suspected monkeypox	Ungraded	14-Dec-17	1-Nov-16	25-Jan-18	16	2	2	12.5%	During weeks 48 and 49 of 2017, three suspected cases of Monkeypox were reported from Maryland and Rivercess Counties. Since November 2016, a cumulative of 16 suspected cases and two deaths have been reported in Grand Cape Mount(4), Rivercess(11) and Maryland(1). Two cases have been confirmed to date and laboratory testing of samples collected from five other cases is ongoing.
Liberia	Measles	Ungraded	24-Sep-17	6-Sep-17	3-Dec-17	1 607	255	2	0.1%	From week 1 to week 48, 1 607 cases were reported from 15 counties, including 225 laboratory confirmed, 336 clinically compatible and 199 epi-linked. Nimba county has had the greatest cumulative number of cases to date (235). Children between 1-4 years accounted for 49% of the cases.

Liberia	Lassa fever	Ungraded	14-Nov-17	1-Jan-17	24-Nov-17	70	28	21	30.0%	Since the beginning of 2017, a total of 70 suspected Lassa fever cases including 21 deaths (CFR: 30%) have been reported from nine counties in Liberia. On 12 January 2018, a suspected case reported from Nimba County was confirmed by PCR. Contact tracing is ongoing in Liberia and Guinea.
Liberia	Scabies	Ungraded	11-Jan-18	11-Dec-17	18-Jan-18	10 850	17	0	0.0%	A total of 10 850 cases have been reported from five counties: Montserrado (9 647), Grand Bassa (687), Rivercess (315), Margibi (185), and Bong (16). All 17 confirmed cases have been reported from Montserrado county.
Madagascar	Cyclone	Ungraded	5-Jan-18	5-Jan-18	6-Jan-18	-	-	-	-	On 5 January 2018, tropical Cyclone AVA reached the East coast of Madagascar. The most affected regions were Analanjirofo, Atsinanana and Vatovavy-Fitovinany. As of 6 January 2018, 1 009 people had been affected, including 695 displaced. Two dead and 21 injured were reported in the Atsinanana region.
Madagascar	Plague	G2	13-Sep-17	13-Sep-17	9-Feb-18	2 634	539	230	8.7%	Cases include pneumonic (2 015, 77%), bubonic (412, 16%), septicemic (1) and unspecified (206, 8%) forms of disease. Of the 2 015 clinical cases of pneumonic plague, 397 (20%) have been confirmed, 635 (32%) are probable and 983 (49%) remain suspected. The trend in the number of cases has been decreasing since 10 October 2017.
Malawi	Cholera	Ungraded	28-Nov-17	20-Nov-17	28-Jan-18	308	5	4	1.3%	As of 28 January 2018, a total of 308 cases including 4 deaths had been reported from 7 districts: Karonga (211 cases with 4 deaths), Nkhatabay (20 cases), Kasungu (1 case), Dowa (4 cases), Salima (10 cases), Lilongwe (58 cases) and Mulanje (3 cases).
Mali	Dengue fever	Ungraded	4-Sep-17	1-Aug-17	10-Dec-17	429	33	0	0.0%	In week 49, no suspected cases were reported. No confirmed cases have been reported since week 41. All cases have been reported from Bamako and the Kati health district northwest of Bamako.
Mali	Humanitarian crisis	Protracted 1	n/a	n/a	19-Nov-17	-	-	-	-	The security situation remains volatile in the north and centre of the country. At the last update, incidents of violence had been perpetrated against civilians, humanitarian workers, and political-administrative authorities.
Mauritania	Dengue haemorrhagic fever	Ungraded	30-Nov-17	6-Dec-17	13-Dec-17	37	37	-	-	On 30 November, the MoH notified 3 cases of dengue fever including one hemorrhagic case (Dengue virus type 2) with a history of Dengue virus type 1 infection in 2016. Out of 100 samples collected at the Teyarett health centre, 83 cases tested positive for dengue on RDT. On 12 December, the national reference laboratory confirmed the diagnosis of 37 out of 49 RDT positive samples collected between 16 November and 11 December 2017.
Mozambique	Cholera	Ungraded	27-Oct-17	12-Aug-17	26-Jan-18	1 597	-	1	0.1%	The cholera outbreak is ongoing. Cases have been reported from two provinces and five districts. Affected districts in Nampula province are (Memba, Erati, Nacaroa, and Nampula city), and Pemba city in Cabo Delgado province. The outbreak started in mid-August 2017 from Memba district. Erati district started reporting cases from week 41, Nacaroa started reporting cases from week 42, and Cabo Delgado Province started reporting cases from week 1 of 2018.
Namibia	Hepatitis E	Ungraded	18-Dec-17	8-Sep-17	4-Feb-18	643	50	3	0.5%	Detailed update given above.

Namibia	Cholera	Ungraded	31-Jan-18	25-Jan-18	31-Jan-18	1	1	0	0.0%	On 25 January 2018, a 10-year old schoolboy was admitted to a hospital in Windhoek after presenting with diarrhoea, vomiting, and dehydration. The patient fell ill after sharing food with two other classmates who subsequently developed similar symptoms. On 29 January 2018 stool samples isolated from the patient tested positive for <i>Vibrio Cholerae</i> .
Niger	Humanitarian crisis	G2	1-Feb-15	1-Feb-15	11-Aug-17	-	-	-	-	The security situation remains precarious and unpredictable. On 28 June 2017, 16 000 people were displaced after a suicide attack on an internally displaced persons camp in Kablewa. In another attack on 2 July 2017, 39 people from Ngalewa village, many of them children, were abducted. The onset of the rainy season is impeding the movements of armed forces around the region.
Nigeria	Humanitarian crisis	Protracted 3	10-Oct-16	n/a	17-Dec-17	-	-	-	-	The protracted conflict has resulted in widespread population displacement, restricted access to basic social services, including healthcare and protection needs, and a deepening humanitarian crisis. An estimated 8.5 million people have been affected and are in need of life-saving assistance, including 1.7 million IDPs.
Nigeria	Cholera (nation wide)	Ungraded	7-Jun-17	1-Jan-17	10-Dec-17	3 714	43	84	2.3%	Between weeks 1 and 49, 3 714 cases were reported from 20 states compared to 727 suspected cases from 14 states during the same period in 2016. The cumulative total of cases and deaths in 2017 surpasses that observed during the same period in 2016 (727 suspected cases, 32 deaths).
Nigeria	Botulism	Ungraded	12-Jan-18	9-Jan-18	16-Jan-18	3	-	2	66.7%	On 9 January 2018, the NCDC was notified of two suspected cases of botulism involving a husband and his wife, both with symptoms onset on 7 January 2018. A third suspected case, their daughter, was admitted on 11 January with similar symptoms. The wife died on 8 January 2018. The father died on 15 January. The daughter is still admitted. Foodborne botulism was suspected based on the typical signs and symptoms such as cranial nerve paralysis. The diagnosis is yet to be confirmed by the laboratory. So far, the source of infection has not been identified.
Nigeria	Lassa fever	G2	24-Mar-15	1-Dec-16	25-Jan-18	1 319	385	149	11.3%	Cases have been reported from 13 active states: Anambra, Bauchi, Benue, Delta, Ebonyi, Edo, Imo, Kogi, Lagos, Nasarawa, Ondo, Plateau, and Taraba. Ten healthcare workers have been affected in three states Ebonyi (7), Nasarawa (1), Kogi (1), and Benue (1).
Nigeria	Hepatitis E	Ungraded	18-Jun-17	1-May-17	31-Dec-17	1 651	182	8	0.6%	The number of cases has been decreasing since week 51. Forty-three new cases were reported in Kala/Balge LGA in week 52 (ending 31 December 2017).
Nigeria	Yellow fever	Ungraded	14-Sep-17	7-Sep-17	10-Jan-18	367	33	45	12.3%	A total of 367 suspected cases have been reported from sixteen states: Abia, Anambra, Borno, Edo, Enugu, Kano, Katsina, Kebbi, Kogi, Kwara, Lagos, Nasarawa, Niger, Oyo, Plateau, and Zamfara. Thirty-three cases from seven states (Kano, Kebbi, Kogi, Kwara, Nasarawa, Niger, and Zamfara) have been laboratory-confirmed at IP Dakar.
Nigeria	Monkeypox	Ungraded	26-Sep-17	24-Sep-17	22-Dec-17	197	68	2	1.0%	Suspected cases are geographically spread across 22 states and the Federal Capital Territory (FCT). Sixty-eight laboratory-confirmed cases have been reported from 14 states/territories (Akwa Ibom, Abia, Bayelsa, Benue, Cross River, Delta, Edo, Ekiti, Enugu, Lagos, Imo, Nasarawa, Rivers, and FCT).

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Nigeria	Meningitis	Ungraded	26-Dec-17	1-Sep-18	18-Jan-18	419	74	77	18.4	Cases have been reported from eight States; Zamfara (240), Katsina (72), Sokoto (22), Jigawa (24), Bauchi (17), Cross River (17), Kebbi (12), Yobe (9), Borno (3), Adamawa (2) and Kaduna (1). As of 18 January 2018, 74 of 155 (48%) samples tested were positive, including 46 (62%) positive for Neisseria meningitidis serogroup C (NmC).
São Tomé and Príncipe	Necrotising cellulitis/fasciitis	Protracted 2	10-Jan-17	25-Sep-16	17-Dec-17	2 422	0	0	0.0%	Over past 11 weeks, the incidence of new cases remained stable with an average of 32 cases per week. In week 50, 37 cases reported across six of the seven districts: Me-zochi (12), Agua Grande (9), Lobata (2), Cantagalo (12), Lembá (1) and Príncipe (1). Currently, 22 cases are receiving care in hospital and no deaths have been directly attributed to the infection.
Seychelles	Dengue fever	Ungraded	20-Jul-17	18-Dec-15	21-Jan-18	4 445	1 429	-	-	As of 21 January, 4 445 cases have been reported from all regions of the three main islands (Mahé, Praslin, and La Digue). The trend in the number of cases has been decreasing since week 23.
South Africa	Listeriosis	G1	6-Dec-16	4-Dec-16	5-Feb-18	852	852	107	12.6%	Detailed update given above.
South Sudan	Humanitarian crisis	G3	15-Aug-16	n/a	4-Feb-18	-	-	-	-	The conflict in South Sudan has left more than 6 million people in need of humanitarian assistance. There is relative calm although there are sporadic security threats being observed in different locations across the country, such as cattle raiding in lakes, arm robbery in Kapoetas as well as in Torit, and tense security situation in Mayom, Leer and Rubkona. Risk of infectious disease outbreak remains high in many parts of the country.
South Sudan	Rift Valley fever (RVF)	Ungraded	28-Dec-17	7-Dec-17	9-Feb-18	28	5	3	10.7%	An initial cluster of three suspected cases was reported from Yirol East County, all of whom died. Five additional suspected cases showed evidence of Rift Valley fever infection by serology (one was IgM and IgG positive for RVF, four were IgG positive only); these five cases were negative for RVF on PCR. Twelve other suspected cases were later classified as non-cases following negative RVF results on serology and PCR. Laboratory testing is pending for the eight suspected cases most recently identified.
Tanzania	Cholera	G1	20-Aug-15	1-Jan-17	4-Feb-18	5 461	-	111	2.0%	From Weeks 1 to 5 of 2018, a total of 476 cases with 12 deaths (CFR: 2.5%) were reported. In week 5, 151 cases with 3 deaths (CFR:2%) have been reported from four regions: Dodoma (90 cases and 3 deaths), Ruvuma (46 cases), Rukwa (12 cases) and Kigoma (3 cases). This week, Kigoma Region reported three suspected cases among asylum seekers after three weeks of zero reporting from the host communities.
Uganda	Humanitarian crisis - refugee	Ungraded	20-Jul-17	n/a	31-Dec-17	-	-	-	-	The influx of refugees to Uganda has continued as the security situation in the neighbouring countries remains fragile. According to UNHCR, between 1 - 4 January 2018, 207 refugees from South Sudan entered Uganda. The total number of registered refugees and asylum seekers in Uganda stands at 1 395 146, as of 31 December 2017. Approximately 75% of the refugees are from South Sudan and 61% are children under 18.

Uganda	Measles	Ungraded	8-Aug-17	24-Apr-17	3-Oct-17	623	34	-	-	The outbreak is occurring in two urban districts: Kampala (310 cases) and Wakiso (313 cases).
Uganda	Rift Valley fever (RVF)	Ungraded	22-Nov-17	14-Nov-17	27-Jan-18	6	6	5	83.3%	Two additional confirmed cases were identified through enhanced surveillance. One of these confirmed cases was a migrant from south Sudan who was living in the Bidibidi refugee settlement, he died on 21 January 2018. All previously suspected cases have tested negative. To date six districts have been affected: Kiboga, Mityana, Kiruhura, Kyankwanzi, Arua and Buikwe. They are all located within the cattle corridor.
Uganda	Crimean-Congo haemorrhagic Fever (CCHF)	Ungraded	27-Dec-17	23-Dec-17	31-Jan-18	2	2	0	0.0%	On 17 January 2018 a second CCHF case was identified at the Kiwoko Hospital. On 18 January 2018 qRT-PCR results from the UVRI VHF-laboratory were positive for CCHF. As of 31 January 2018, both confirmed cases have been discharged and 32 contacts are currently under follow-up.
Zambia	Cholera	G1	4-Oct-17	4-Oct-17	23-Jan-18	3 635	67	78	2.1%	On 23 January 2018, 32 new cases with no deaths were reported in Lusaka district and one case and no deaths were reported from Chongwe district. Since the start of the outbreak, Lusaka district reported a total of 3 424 cases with 70 deaths (CFR: 2.0%). The cumulative number of cases from other districts is 211 including 8 deaths.
Zimbabwe	Cholera	Ungraded	22-Jan-18	8-Jan-18	7-Feb-18	101	7	4	4.0%	Chegutu Municipality in Mashonaland West Province of Zimbabwe, southwest of the Capital City Harare remains the hotspot of this outbreak. As of 7 February 2018, a cumulative total of 101 cases and 4 deaths (CFR: 4%) have been reported. Of these, 88 cases are from Chegutu, 12 cases are from different peri-urban areas of Chegutu, and one case from Msengezi area.
Zimbabwe	Typhoid fever	Ungraded	-	1-Oct-17	21-Jan-18	2 444	160	0	0.0%	Since the beginning of the outbreak 2 444 cases including 160 confirmed cases have been reported. The outbreak has spread from its epicentre in Matapi to other suburbs in Harare and areas outside of Harare.
Recently closed events										
South Sudan	Cholera	Ungraded	25-Aug-16	18-Jun-16	7-Feb-18	20 438	512	436	2.1%	Detailed update given above.

†Grading is an internal WHO process, based on the Emergency Response Framework. For further information, please see the Emergency Response Framework: <http://www.who.int/hac/about/erf/en/>.

Data are taken from the most recently available situation reports sent to WHO AFRO. Numbers are subject to change as the situations are dynamic.

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